GCH PEDIATRICS

PATIENT INFORMATION

Patient Name_____**Gender: __M __F Birthdate:**_____

Address:_____
Street City State Zip Code

Home Phone: _____ **Cell Phone:** _____ **Soc Sec Num:** _____

Primary Physician: _____
Doctor Address City State Zip Phone #

PARENT INFORMATION

Mother's Name: _____ **Birthdate:**_____ **SS#:** _____

Address: _____
Street City State Zip Code

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Father's Name: _____ **Birthdate:**_____ **SS#:** _____

Address: _____
Street City State Zip Code

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

EMERGENCY CONTACT

Name: _____ **Relationship:** _____ **Phone:** _____

How were you referred to us?

__Friends/Family __Newspaper __Flyer __Doc Office __ER __Facebook __Staff Referral __Other_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ Phone #: _____

Claim Address: _____
Street City State Zip Code

Policy Number: _____ **Group Name:** _____ **Group Number:**_____ **Copay:**_____

Policy Holder's Name: _____ **Phone #:**_____ **DOB:** _____ **SS#:** _____

Address: _____ **Relationship:** _____ **Employer:** _____

SECONDARY INSURANCE: _____Phone #: _____

Claim Address: _____
Street City State Zip Code

Policy Number: _____ **Group Name:** _____ **Group Number:**_____ **Copay:**_____

Policy Holder's Name: _____ **Phone #:**_____ **DOB:** _____ **SS#:** _____

Address: _____ **Relationship:** _____ **Employer:** _____

Continued on Back

GCH PEDIATRICS

Please list any medications that you take: _____

_____

_____

Please list any allergies you have:_____

_____

_____

AUTHORIZATION

Responsible for Payment: If insurance payment or legal settlement is involved in the problem for which the patient is seeing the physician, I understand that I am personally responsible for the amount not covered by insurance or legal settlement.

Authorization to Release Information: I hereby authorize the release of any information necessary in the course of my examination; treatment, or the process of a claim.

Authorization to Pay Benefits: I hereby authorize payment to GCH Family Medicine Clinics and Guthrie County Hospital of all medical and/or surgical benefits.

Signature: _____ Date: _____